LOEB
ORTHODONTICS, LLC

PATIENT INFORMATION:

Date _____

Patient's name _____ Date of birth _____

Address _____ Patient's age _____

City, State, Zip _____ Home phone _____

Patient's school _____ Grade _____

Nickname _____ Hobbies, Interests _____

Sports _____ Pets _____

Mother's name _____ Home phone _____

Address _____ Cell phone _____

City, State, Zip _____

Occupation _____ Employer _____

Bus. address _____ Bus. phone _____

City, State, Zip _____ Social Security number _____

Father's name_____ Home phone _____

Address _____Cell phone _____

City, State, Zip _____

Occupation _____ Employer _____

Bus, address _____ Bus. phone _____

City, State, Zip _____ Social Security number _____

For our automated reminder service, please choose your contact preference – select one & clearly write number:

Home phone _____ or Cell phone _____

E-mail address, for announcements, messages and website interactivity _____

Whom may we thank for referring you to our office? _____

Do you have any friends or relatives in our practice? _____

Insurance information: Policy/Company name _____ Policy number _____

Policy/Company name _____ Policy number _____

Special requests, considerations or comments _____

_____

LOEB ORTHODONTICS, LLC

Medical-Dental Questionnaire:

Patient's Name_____Date of Birth_____

MEDICAL HISTORY

Patient's Physician_____Town_____Phone_____

	YES	NO
❊ Is your physician currently treating you for any reason?.....	❑	❑
If yes, please explain_____		
❊ Have you ever been hospitalized?.....	❑	❑
If yes, please explain_____		
❊ Are you currently taking any pills, drugs or other medications?.....	❑	❑

If yes, please list name & reason: 1. _____ Reason_____

2. _____ Reason_____

3. _____ Reason_____

4. _____ Reason_____

❊ Women, are you pregnant? YES NO If yes, when do you expect? _____

❊ Do you have, or have you ever had, any of the following?

- ❑ 1. Heart disease or chest pains
- ❑ 2. High Blood Pressure
- ❑ 3. Heart Murmur
- ❑ 4. Pacemaker or artificial valves
- ❑ 5. Rheumatic fever
- ❑ 6. Diabetes
- ❑ 7. Blood disorders or anemia
- ❑ 8. Lung or breathing problems
- ❑ 9. Asthma
- ❑ 10. Kidney or liver problems
- ❑ 11. Hepatitis
- ❑ 12.Thyroid problems
- ❑ 13. Stomach or intestinal problems
- ❑ 14. Tuberculosis
- ❑ 15. Arthritis
- ❑ 16. Artificial joint replacements
- ❑ 17. Epilepsy or seizures
- ❑ 18. Syphilis, gonorrhea, AIDS
- ❑ 19. Tumors or cancer
- ❑ 20. Radiation therapy
- ❑ 21. Shortness of breath

❊ If yes to any of the above, please explain_____

_____

❊ Have you ever been told to take antibiotics before dental procedures?.....	❑	❑
If yes, please explain_____		
❊ Are you allergic to any medications or drugs?.....	❑	❑
If yes, please explain_____		
❊ Do you have any other allergies?.....	❑	❑
If yes, please explain_____		

DENTAL HISTORY

Patient's Dentist_____Town_____Phone_____

❊ Approximate date of last dental check-up?_____

❊ Do you have discomfort in your teeth or jaw?	❑	❑
If yes, please explain_____		
❊ Do your joints pop, click or grate when opening widely?	❑	❑
If yes, please explain_____		
❊ Do you clench or grind your teeth?	❑	❑

I agree to notify you if there is any change in my (child's) health status.

Signature_____ Date_____

PRINT FORM

ADA American Dental Association® Dental Claim Form

Please complete the highlighted items below:

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID